Oahe Child Development Center, Inc.

2307 E. Capitol Avenue
Pierre, South Dakota 57501

Phone: (605) 224-6603
Fax #: (605) 224-0850

APPLICATION

We are pleased that you are applying for our program! Oahe Child Development Center (OCDC) provides a comprehensive program that includes early childhood education, health, mental health, nutrition, family partnerships, and advocacy services for enrolled families.

To complete the application process, OCDC Head Start/Early Head Start will need the following information:

- ☐ **COMPLETED APPLICATION**
- ☐ **FAMILY'S PROOF OF INCOME (one of the following)**
  - 1040, pay stubs, and/or proof of child support
  - Proof of SSI, TANF, or SNAP
  - Paperwork showing DSS placement, Kinship placement, etc
- ☐ **CHILD'S BIRTH RECORD**
- ☐ **IMMUNIZATION RECORD (Please see back side of this page for program requirements.)**

***PLEASE NOTE*: CHILD MUST BE UP-TO-DATE ON ALL IMMUNIZATIONS TO BE CONSIDERED FOR FULL DAY CLASS ENROLLMENT AS PER SD CHILDCARE LICENSURE REQUIREMENTS.**

Once your application has been returned and income has been verified, you or your child will be placed on a waiting list. We will start accepting income eligible children in the middle of May. Over income families will be notified starting the third week in July. If you do not receive notification during this time, you or your child will remain on the wait list until an opening occurs. During the school year, all applications will be reviewed at the time of an opening.

If you have any questions, please call me at 605-224-6603.

Hannah Carda

Recommended Immunization Schedule

Vaccine	Birth	1 Mo	2 Mo	4 Mo	6 Mo	12 Mo	15 Mo	18 Mo	19-23 Mo	4-6 Yr
Hepatitis B (Hep B)	#1	#2			#3					
Diphtheria, Tetanus, Pertussis (DTP)			#1	#2	#3		#4			#5
Haemophilus influenzae Type b (Hib)			#1	#2	#3*	#4				
Inactivated Poliovirus			#1	#2	#3					#4
Measles, Mumps, Rubella (MMR)						#1				#2
Varicella						#1				#2
Hepatitis A						#1 & #2 (6 months apart)				
Pneumococcal (PVC)			#1	#2	#3	#4				
		= Immunization is to be given within this range of time								

IMMUNIZATION REQUIREMENTS – effective September 2016

Combination Vaccines Often Seen on Immunization Records:

Pediarix = DTaP, Hep B, Polio
Pentacel = DTaP, Hib, Polio
Kinrix = DTaP, Polio
MMRV = Varicella, MMR

***** NOTE: The Pedvax or ComVax Hib is 3 doses, with the 6-month immunization not required. All other Hib series are 4 doses using the schedule above.

Recommended well child exams and dental exam Schedule

Head Start federal guidelines require your child to be up to date on well child exams.

You need to determine if your child is up to date. Obtain copies of most current exams and lab results and bring with you to your enrollment or turn them in with the application. If your child is not up to date you will need to make an appointment ASAP with your child's medical provider/dentist to stay on track per guideline below**:**

- **Well-Child Exam**-Well child exams are normally done at 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 &/or 18 months, 2 year, 3 year, 4 year and 5 year.
- **Dental Exam**- First dental exam required by 12 months of age and then every year.
- **Blood lead level**- required at 12 and 24 months of age. If you do not have record of results or child was not tested, Head Start requires a level be drawn between 36 to 72 months of age.
- **Hemoglobin level**-required at 12 months of age.

PLEASE COMPLETE ALL AREAS OF THIS APPLICATION.

OAHE CHILD DEVELOPMENT CENTER

Child Application

Early Head Start / Head Start

2307 E. Capitol Pierre, SD 57501
Phone: 605-224-6603 Fax: 605-224-0850

OFFICE USE ONLY Date Received: _____

EHS: _____ HS: _____

NEW____ **RETURN** _____ **TRANSF** ____

IMMUNES: _____1/2 DAY _____ FULL DAY

ENCODED _____ County _____

Applicant Information (Child)

First Name MI Last Name

Date of Birth: _____/_____/_____

☐**Male** ☐**Female**

Has the applicant been enrolled in a Head Start/Early Head Start program before? _____
If so, where? _____
When? _____

Living Address		**Mailing Address**	
Street:		Street/PO Box:	
Town/City:	State: Zip Code:	Town/City:	State: Zip Code:
County:		School District:	

Applicant lives with: *(check all that apply)*

☐Mother ☐Stepfather
☐Father ☐Stepmother
☐Grandparent(s) ☐Foster Parent
☐Other (specify) ☐Other Relative
_____ _____
_____ _____

Language(s) spoken in the child's home?

Primary: _____

Secondary: _____

How well does the applicant speak English?

_____

*****Race Key at Bottom of page**

	Race		*Circle one*	
Applicant		Hispanic?	Y ☐	N ☐
Primary Guardian		Hispanic?	Y ☐	N ☐
Secondary Guardian		Hispanic?	Y ☐	N ☐

Primary Parent/Guardian		**Secondary Parent/Guardian**	
First Name Middle Name Last Name		First Name Middle Name Last Name	
Date of Birth:	Relationship to Child:	Address:	
Telephone Number Information:		Date of Birth:	Relationship to Child
Home/Cell _____ Work: _____		Telephone Number Information: Home/Cell: _____ Work: _____	
E-mail: _____		E-mail: _____	

Custodial Information:

☐ Both biological parents
☐ Sole Custody
☐ Joint Custody
☐ Physical Custody: explain who has legal custody
_____

Are there special visitation orders we should be aware of?

☐ No
☐ Yes, please mark and provide us with a copy
☐Foster Care/Custody of State of South Dakota
☐Court ordered Agreements
☐Restraining Orders

Please list all OTHER persons living in the home

First Name Last Name	Date of Birth	Relationship to Child	Race

PLEASE NOTE THE OPTIONS BELOW ARE ONLY FOR CENTER BASED CHILDREN AGES 3-5 IN THE PIERRE CENTERS*

PLEASE RANK YOUR 1ST, 2ND, AND 3RD CHOICES. WE ONLY HAVE A CERTAIN NUMBER OF SLOTS FOR EACH OPTION AND CANNOT GUARANTEE ANY ENROLLMENT SLOT.

_____ AM ½ day class Monday-Thursday, (8am-11:30am)
PM ½ day class Monday-Thursday, (11:45am-3:15pm)
Full day class Monday-Thursday and some Fridays (8am-3pm)

_____ Are you interested in the *After School Program* that operates 3:00pm-5:15pm Monday-Thursday and some Fridays?

Does your family receive, (or is certified for), daycare assistance? ☐ **No** ☐ **Yes**

*****Race Key: American Indian (AI), Asian (AS), Black or African American (B), Native Hawaiian (NH), White (W),Biracial / Multi-Racial (MR), Other (O)**

Primary Parent/Guardian Employment and Education	Secondary Parent/Guardian Employment and Education
Employment: ☐ Full time ☐ Part time ☐ Seasonal ☐ Unemployed Employer Name: _____ Are you attending job training? ☐ Yes ☐ No Are you in school? ☐ Yes ☐ No If yes, Where? _____ Are you active in any branch of the United States Military? ☐ Yes ☐ No Are you a **Veteran** of the United States Military? ☐ Yes ☐ No Highest level of education completed: ☐ 9th or less ☐ 10th ☐ 11th ☐ HS Graduate ☐ Some college ☐ BS/BA ☐ Associate's Degree ☐ 2 year college ☐ Master's ☐ Advanced ☐ Vocational ☐ Doctorate ☐ Other _____	Employment: ☐ Full time ☐ Part time ☐ Seasonal ☐ Unemployed Employer Name: _____ Are you attending job training? ☐ Yes ☐ No Are you in school? ☐ Yes ☐ No If yes, Where? _____ Are you active in any branch of the United States Military? ☐ Yes ☐ No Are you a **Veteran** of the United States Military? ☐ Yes ☐ No Highest level of education completed: ☐ 9th or less ☐ 10th ☐ 11th ☐ HS Graduate ☐ Some college ☐ BS/BA ☐ Associate's Degree ☐ 2 year college ☐ Master's ☐ Advanced ☐ Vocational ☐ Doctorate ☐ Other _____

Family Resources Information

Does your family receive any of the following types of services or financial assistance? (Please indicate all that apply):

☐ SNAP (Food Stamps)	☐ Foster Care/Adoption subsidy	☐ Child Support/Alimony
☐ WIC	☐ Unemployment Insurance	☐ Financial Aid/Student Loans
☐ Public Assistance – TANF	☐ Supplemental Security Income (SSI)	☐ None Listed

Are there any other concerns or family situations that we should be aware of to help meet your child's needs? (Such as a recent divorce, move, parental health, counseling, parent absent due to incarceration or military duty, etc.)

☐ No ☐ Yes If yes, please explain: _____

_____

_____

Additional Information:	Income Verification:
Is anyone in your household currently pregnant? ☐ No ☐ Yes *If yes, would you like an application?* ☐ Yes ☐ No	*I understand that my income must be verified and have attached:* ☐ Foster Care Verification ☐ Pay-stubs ☐ 1040 or W-2 ☐ Unemployment ☐ Proof of SNAP/TANF/SSI ☐ Other: _____
How Did You Hear About Us:	**Were You Referred by Another Agency:**
☐ OCDC Website ☐ Facebook /Social Media ☐ Newspaper ☐ Personal Contact ☐ TV/Radio announcement	☐ Child Welfare Agency ☐ Public School/EC Program ☐ Health care provider/dentist ☐ Other _____ ☐ WIC Office/County Health

Special Needs/Services:

Does the applicant have any special needs? ☐ No ☐ Yes If yes, please describe: _____

_____

Is the applicant receiving any special services or currently on an IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? (Examples: medical, speech therapy, physical therapy, occupational therapy, counseling, etc.)

☐ No

☐ Yes If yes, please describe and provide name and address of service provider: _____

Provider: _____ Phone: _____ Address: _____

BEFORE ACCEPTANCE INTO OUR PROGRAM, INCOME MUST BE VERIFIED BY AUTHORIZED OCDC STAFF

Head Start Performance Standards require your child to have up to date well child, dental exams, & immunizations.

My signature gives permission for staff to access my child's immunization records.
The statements and information on this application are true and accurate to the best of my knowledge.

_____

Parent/Guardian Date Parent/Guardian Date

This institution is an equal opportunity provider